SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

MEDICAID HOSPICE POLICY MANUAL

Section: GENERAL INFORMATION

Subject: Hospice Election Statement Sample

Medicaid Hospices may design their Hospice Election Statements. Hospice election statements must contain all the information outlined in Hospice Policy 404, "Content of Election Statement" section.

I, _____ choose to elect the Medicaid hospice benefit and receive
(Beneficiary Name)

Hospice services from _____.
(Hospice Agency Name)

Hospice Philosophy

I acknowledge that I have been given a full explanation and have an understanding of the purpose of hospice care. Hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward a cure. The focus of hospice is to provide comfort and support to both me and my family/caregivers.

Effects of a Medicaid Hospice Election

I understand that by electing hospice care under the Medicaid Hospice Benefit, I am waiving (give up) all rights to Medicaid payments for services related to my terminal illness and related conditions. I understand that while this election is in force, Medicaid will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected. I understand that services not related to my terminal illness or related conditions will continue to be eligible for coverage by Medicaid.

Right to Choose an Attending Physician

I understand that I have a right to choose my attending physician to oversee my care. My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

☐ I do not wish to choose an attending physician.

I acknowledge that my choice of an attending physician is:

Physician's Full Name: _____NPI (if known) _____

Office Address: _____

I acknowledge and understand the above, and authorize Medicaid hospice coverage to be provided by:

_____to begin on: _____
(Hospice Agency Name) (Effective Date of Election)

NOTE: The effective date of the election, which may be the first day of hospice care or later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.

_____ _____
Signature of Beneficiary/Representative Date

☐ Beneficiary is unable to sign

Reason: _____

_____ _____
(Witness signature) Date